MONTANA STATE HOSPITAL
MENTAL HEALTH CENTER
POLICY AND PROCEDURE

CONSULTATION REFERRAL REQUEST

Effective Date: January 10, 2003 **Policy #:** TCU-09

I. PURPOSE: To establish a process to ensure patient needs, other than those directly provided by the T.C.U., are addressed in a timely and efficient manner.

II. POLICY: T.C.U. patients who have needs identified that can not be addressed directly by the T.C.U. or the referring treatment team will request services through the Montana State Hospital consultation referral procedures.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

A. Attending Psychiatrist: will assess patient need and, as appropriate, initiate a consultation referral.

B. Medical Clinic: will execute the referral consultation request.

V. PROCEDURES:

A. Attending Psychiatrist will order services or request consultations for Rehabilitation Services (form attached) or Medical Clinical Services as deemed appropriate.

B. Identified needs of each patient will be addressed or have a clinical justification identified in the medical record as to why they are not addressed.

C. Hospital procedures will be followed in accessing hospital services.

VI. REFERENCES: Administrative Rules of Montana, Mental Health Center: Policies and Procedures 37.106.1908;
Rehabilitation Services Operational Service Plan;
Medical Clinic Operational Services Plan; and
Nursing Operational Services Plan

VII. COLLABORATED WITH: Director of Nursing Services, Medical Physicians

VIII. RESCISSIONS: Policy #TCU-09-99-R, *Transitional Care Unit Consultation Referral Request* dated February 25, 2000; H.O.P.P. #TCU-09-99-N, T.C.U. *Consultation Referral Request* dated

June 15, 1999.

IX. DISTRIBUTION: TCU Policy and Procedure Manuals

X. REVIEW AND REISSUE DATE: January 2006

XI. FOLLOW-UP RESPONSIBILITY: RN Supervisors of the Montana State Hospital Mental Health Center.

XII. ATTACHMENTS: A. Rehabilitation Services Referral Form

_____/___/__ _____/___/__

Ed Amberg Date Thomas Gray, MD Date

Hospital Administrator Medical Director

MONTANA STATE HOSPITAL
REHABILITATION SERVICES REFERRAL FORM

Pt. Name: _____ MSH#: _____ Wing _____

SS#: _____ D.O.B.: _____ Referral Date: _____

[ ] Vocational Therapy

[ ] Resident Employment

[ ] Occupational Therapy

[ ] CD Services
- [ ] A.A.
- [ ] Dual-Diagnosis

[ ] Fire Safety

[ ] Problem Solving

[ ] Adult Ed

[ ] Living Skills

[ ] Computer Lab

[ ] Mental Illness Ed

FUNCTIONAL ASSESSMENTS:

[ ] Range of Motion

[ ] Chemical Dependency

[ ] Independent Household Skills

Special Needs/Concerns/Additional Information:

RESULT OF REFERRAL:

_____ _____
Referring Physician **Date**

_____ _____
Professional Submitting Referral Request **Date**

_____ _____
Rehab Department Head **Date**